

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08414

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
 City or town Bel Air Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Bel Air
 (If outside city or town limits, write RURAL and give nearest town)Street No. 4195
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Francis Trainor Archer

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Alice Monks Archer

7. Birth date of deceased (mo., day, yr.)

June 2 - 1888

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

60221

hrs.

min.

9. Birthplace

Emmorton Harford Md
 (Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

do.FATHER
MOTHER

12. Name

James H. Archer

13. Birthplace

Harford Co Md

14. Maiden name

Margaret Magness

15. Birthplace

Harford Co Md

16. Informant

Margaret Rutledge

Address

Bel Air Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

8/25/48

Cemetery or crematory

Mt. Carmel Methodist

Location

Emmorton Md

18. Funeral director

W. H. Archer

Address

Benson Md19. 8/23 48 Fowood
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 23rd 1948 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 23rd 1948 to Aug. 23rd 1948
 and that I last saw him alive on Aug. 23rd 1948

Immediate cause of death

Coronary thrombosis

DURATION

1 hour

Due to

Arterio-sclerosis

unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. F. Van Bibber

M, D, or other

Address

Bel Air MdDate signed Aug 23/48

RECEIVED

AUG 25 1946

BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford
 City or town Aberdeen, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days
 Hospital, institution, or street address where death occurred:

32 Hanover St.

How long in hospital or institution?

3. (a) FULL NAME

Frank Blake

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Georgiana Blake

6. (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) Mar. 22, 1920

8. AGE: Years 27 Months 7 Days 12 If less than one day

9. Birthplace Snow Hill, Md.
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name George Blake

13. Birthplace No Record

14. Maiden name Mary Ains

15. Birthplace Snow Hill, Md.

16. Informant Liddie Taylor

Address 32 Hanover St. Aberdeen, Md.

17. Removal Date thereof Aug. 4, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Wesley

Location Snow Hill, Md.

18. Funeral director Elmer E. Bullock

Address 556 Lewis St. Hanover, Md.

19. Aug 4 19 48 Nellie St. Riley
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother) Worcester

State Maryland County Washington

City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Lyphens St.
 (If rural, give LOCATION)

2. (a) If veteran, name war ✓

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH August 4 19 48 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 19 48 to Aug 4 19 48

and that I last saw him alive on August 4 19 48

Immediate cause of death Pulmonary Edema

Due to Pneumonia

Due to Rheumatic Cardiovascular Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. Welch

Address Haver de Grace

Date signed Aug 4

M. D. or other

RECEIVED

AUG 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1857

1. PLACE OF DEATH:

County Harford
 City or town Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 90 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 307 Fountain
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Carrie Allender Boyd

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife George H. Boyd (dec.)
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Dec. 13, 1857
 8. AGE: Years 90 Months 8 Days II If less than one day _____ hrs. _____ min.
 9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation House wife
 11. Industry or business Unknown
 12. Name 19
 13. Birthplace 19
 14. Maiden name 19
 15. Birthplace 19

16. Informant Laurie M. Boyd (Son)
 Address 307 Fountain St. Havre de Grace, Md.
 17. Burial Date thereof 8/27/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Angel Hill
 Location Havre de Grace, Md.
 18. Funeral director Pennington & Son
 Address Havre de Grace, Md.
 19. Aug. 26 19 48 A. L. Lewis M.D.
 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 19 48 at 10:30 M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 19 46 to Aug 24 19 48
 and that I last saw him alive on Aug 24 19 48
 Immediate cause of death Coronary Artery Disease
 DURATION _____
 Due to _____
 Due to _____
 Other conditions Tuberculosis
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Charles J. Foley M.D.
 Address Havre de Grace, Md. Date signed 8/26/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County HarfordCity or town Howe De Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CecilCity or town Perryville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Howard Bradley

7. Birth date of deceased (mo., day, yr.)

Dec. 9, 1853

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

94810

_____ hrs. _____ min.

9. Birthplace

Oakwood - md.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

md.

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Aug 22, 1948

(month) (day) (year)

Cemetery or crematory

Pleasant Grove Pa.

Location

Pleasant Grove Pa.

18. Funeral director

Address

19. Aug. 19

(Date rec'd by registrar)

19. 48G. L. Lewis M. D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 August 1948 at 4:22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

17 August 1948 to 19 Aug 48and that I last saw him alive on 19 August 1948

Immediate cause of death

DURATION

Pulmonary edemaDue to Left ventricular failureDue to arteriosclerotic cardiovascular diseaseOther conditions Fracture of left femur (new)

(Include pregnancy within 6 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8/17/48Where did injury occur? Perryville (County) md (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Fall Injured at work? 10/5/48Date signed 8/19/4823. SIGNATURE B. Norment M.D.Address Howe de Grace Md.Date signed 8/19/48

RECEIVED

AUG 21 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
City or town Harford de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Harford
City or town Harford de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 559 Lewis Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Hanson Henry Brown

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Margaret Mac Brown
6.(c) If alive, give age 55 years
7. Birth date of deceased (mo., day, yr.) July 24, 1935
8. AGE: Years 63 Months + Days 28 If less than one day X hrs. + min.

9. Birthplace Conowingo, Cecil, Maryland
(Town, county, and state)

10. Usual occupation Chief Cook

11. Industry or business

12. Name Arthur Brown

13. Birthplace Conowingo, Maryland

14. Maiden name Marie Biddy

15. Birthplace Conowingo, Maryland

16. Informant Mrs Margaret Brown

Address 559 Lewis St. Harford de Grace

17. Burial Burial Date thereof Aug 25-48
(Burial, cremation or removal Which) (month) (day) (year)

Cemetery or crematory mt goan A.M.E.

Location Conowingo, Maryland

18. Funeral director Elmer E Bullock

Address 536 Lewis St. Harford de Grace, Md

19. Aug 23 19 48 G. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22, 48 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to Aug 21 1948
and that I last saw him alive on Aug 21 1948

Immediate cause of death Congestive heart failure DURATION 1 month

Due to Hypertensive heart disease 4 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

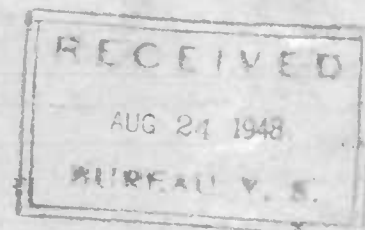
23. SIGNATURE Daniel D. Dolan M. D. or other

Address Harford de Grace Date signed Aug 23 1948

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County HarfordCity or town Edgewood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Edgewood (If outside city or town limits, write RURAL and give nearest town)Street No. 19 Grant St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. John A. Budd

3. (b) Social Security Number

275-05-7029

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lena Marie Budd

7. Birth date of

deceased (mo., day, yr.)

Aug 5 18976. (c) If alive, give age 43 years

8. AGE:

51

Years

Months

Days

If less than one day

9 hrs. min.

9. Birthplace

Gallipolis Ohio
(town, county, and state)

10. Usual occupation

Inspector

11. Industry or business

Army Chemical Center

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14th 1948 at 7:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 14th 1948 to same 19and that I last saw him alive on " 19

Immediate cause of death

Acute coronary occlusion (?)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Noguera MD.
Kingsville Md Date signed 8/14/48

M. D. or other

Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 19 1943

BUREAU V. R.

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08420

FILM No. G 117 SEP 15 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

76

78

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

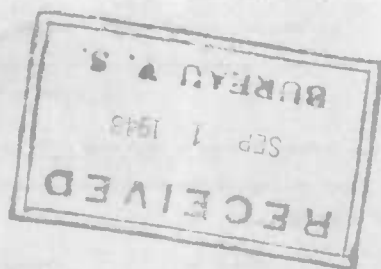
M. D. or other

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
City or town Fallston (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford
City or town Fallston (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Florence Alma Clark

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widow
6. (b) Name of husband or wife D. Chas. Clifford Clark
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 22 1871
8. AGE: Years 77 Months 1 Days 6 If less than one day hrs. min.

9. Birthplace Balto. City
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Robt. Tevin Jones

13. Birthplace Friendship, Annapolis Co. Md.

14. Maiden name Susan A. V. Fields

15. Birthplace Fruitland, Wicomico Co. Md.

16. Informant C. Clark Jones

Address 6500 Rosemont Ave Balto 6.

17. Burial Date thereof Aug 30th 48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Little Falls Friends

Location Fallston, Harford Co Md

18. Funeral director Martin Skurtz

Address Jarrettville Md.

19. 8/29 48 P Howard
(Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 19 48 at 2:40 P. M.

I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 14 19 48 to Aug 28 19 48
and that I last saw him alive on Aug 28 19 48

Immediate cause of death Essential hypertension

Due to Cerebral hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

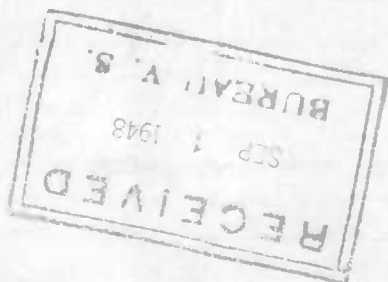
23. SIGNATURE Jed O. Hedrow MD
Address Edgewood Md Date signed Aug 28 1948

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
 City or town Harre du House
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Harford
 City or town Harre du House
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 102 N. Relighting St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Katherine L. Davis

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 B.(b) Name of husband or wife Jacob Davis
Oct. 16, 1866 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.)
 8. AGE: Years 81 Months 10 Days 22 If less than one day hrs. min.

9. Birthplace Russia
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Mr. Abe Davis

Address Harre du House Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 8/10/48
 (month) (day) (year)

Cemetery or crematory Baltimore Hebrew

Location Balt. Md.

18. Funeral director David Isaacson & Son

Address 1902 Eutaw Place

19. Aug. 8 19 48 J. P. Lewis M.D.
 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7 19 48, at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 47 to Aug 7 19 48

and that I last saw him alive on Aug 10 19 48

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to Typhoid

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Signature Charles J. Foley M.D.

Address Harre du House Md.

Date signed 8/17/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 185-

1. PLACE OF DEATH:

County HarfordCity or town Harre De Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Harford Memorial HospitalHow long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Abedeen
(If outside city or town limits, write RURAL and give nearest town)Street No. 431 Lorraine St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

KYLE E. GRACE

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary J. Grace

7. Birth date of

deceased (mo., day, yr.)

Sept. 19th 19056. (c) If alive, give age 44 years

8. AGE:

Years

Months

Days

If less than one day

4210hrs.min.

9. Birthplace

Virginia
(Town, county, and state)

10. Usual occupation

Used cars dealer

11. Industry or business

MOTHER

FATHER

12. Name

David Grace

13. Birthplace

Virginia

14. Maiden name

Isabell Bishop

15. Birthplace

Virginia

16. Informant

Mrs. Mary J. Grace

Address

431 Lorraine

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug 8, 1948
(month) (day) (year)

Cemetery or crematory

Coakesbury

Location

Abingdon Ind.

18. Funeral director

Herby Taxing & Sons

Address

Abedeen Md.

19. Aug 6

19 48

A. L. Lewis M.D.

Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

5 AUGUST 1948 at 3:24 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 August19 48 to 5 August 1948and that I last saw him alive on 5 August 1948

Immediate cause of death

Respiratory failure

DURATION

Due to

massive subarachnoid
hemorrhage

Due to

hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

ABT Marmen M.D.Harre De GraceDate signed Aug 48

08423

83a

185-

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 9 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County.....Baltimore
 City or town.....Route 40 near Lane & Broad
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Maryland County.....Baltimore
 City or town.....Lane & Broad
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....World War #1

3. (a) FULL NAME

Harry W. Hall

3. (b) Social Security Number

4. Sex.....male 5. Color or race.....Colored 6.(a) Single, married, widowed, or divorced.....single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years
 T. Birth date of deceased (mo., day, yr.).....July 7 - 1894

8. AGE: Years.....54 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....Aberdeen, Harford Co. Md.
 (Town, county, and state)

10. Usual occupation.....Day Laborer

11. Industry or business.....Aberdeen Groving Grounds

12. Name.....Harry Hall

13. Birthplace.....Maryland

14. Maiden name.....Annice W. Lewis

15. Birthplace.....Aberdeen Md.

16. Informant.....Mrs. Blanch R. Tilden

Address.....#49 Hanover St. Aberdeen Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof.....Aug 4 - 1948
 (month) (day) (year)

Cemetery or crematory.....Union M. C.

Location.....Near Aberdeen

18. Funeral director.....Henry Topping Sons

Address.....Aberdeen Md.

19. Aug. 2 19 48 A. L. Lewis M.D.
 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....August 1 19 48 at 2:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION

Intracranial hemorrhage
Compound fracture both
legs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....accident Date of.....8/1/48

Where did injury occur?.....near Lane & Gros Harford Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....Route #40

Means of injury.....pedestrian hit by Injured at work?

23. SIGNATURE.....W. D. Lewis M.D.

Address.....Aberdeen Md. Date signed.....8/1/48

08424

1702

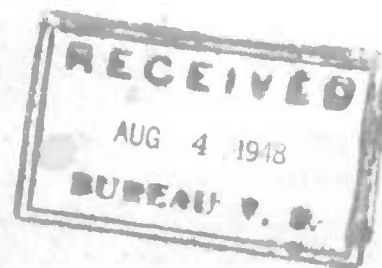
185

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

AUG 4 1918

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date and age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08425

FILM No. G 117 AUG 24 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH

County Hartford
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution? 3 yr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Hartford
City or town Rural - Bel Air
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bel Air
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George J. Hartman

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Kathleen Hartman

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1867 1869 6.(c) If alive, give age 81 years

8. AGE: Years 78 Months 10 Days 1 If less than one day hrs. min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual occupation Laborman

11. Industry or business

12. Name Francis Hartman

13. Birthplace Germany

14. Maiden name Susan McKinley

15. Birthplace Maryland

16. Informant Mr. Thomas F. McQueen

Address Atwood Maryland

17. Burial Date thereof Aug 18, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Smith Chapel

Location Churchville Md

18. Funeral director Howard K. McCombs

Address Atwood Maryland

19. 8/18 48 Potomac
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 48 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 19 48 to Aug 15 19 48 and that I last saw him alive on Aug 15 19 48

Immediate cause of death CORONARY OCCLUSION DURATION 6 hrs?

Due to

Due to

Other conditions CHR. CARDIOVASCULAR DISEASE,
DECOMPENSATED 1 yr?
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M.D.
M. D. or other

Address Forest Hill Md Date signed 8/16/48

RECEIVED

AUG 19 1943

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19.48 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 5

19.43

to Aug. 29

19.48

and that I last saw him

alive on

August 29

19.48

Immediate cause of death

Cerebral Hemorrhage

DURATION

12 hrs.

Due to

Due to

Other conditions

Chronic Cardiovascular Disease with Hypertension
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wesland P. Hudson
M. D. or other

Address

Forest Hill Md

Date signed 8/30/48

RECEIVED

SEP 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
 City or town Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 614 S. Washington
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Anna L. Hipple

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife John A. Hipple
 6. (c) If alive, give age 84 years
 7. Birth date of deceased (mo., day, yr.) Aug. 15, 1863
 8. AGE: Years 84 Months II Days 27 If less than one day
 hrs. min.

9. Birthplace Pennsylvania
 (Town, county, and state)
 10. Usual occupation House Wife
 11. Industry or business

FATHER 12. Name Wm. G. Cheyney
 13. Birthplace Pa.
 MOTHER 14. Maiden name Louisa Baker
 15. Birthplace Pa.

16. Informant Louise Hipple
 Address 614 S. Washington, Havre de Grace

17. Burial Date thereof Aug. 13, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Angel Hill
 Location Havre de Grace

18. Funeral director Pennington & Son
 Address Havre de Grace, Md.

19. Aug. 12 19 48 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 19 48 4:35 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 19 48 to Aug 11 19 48
 and that I last saw him alive on August 11 19 48.

Immediate cause of death Arteriosclerosis DURATION 15 yrs.

Due to

Due to

Other conditions Chronic Myocarditis 12 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

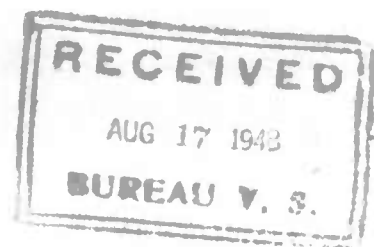
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. Johnson, M.D. M. D. or otherAddress Post 83 Post, Ind. Date signed 8/12/48



08428

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 182

1. PLACE OF DEATH:

County HarfordCity or town Fallston Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HarfordCity or town Fallston Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Daniel A Hrubesh

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Nov 9 - 1946

8. AGE:

Years

Months

Days

If less than one day

19

hrs.

min.

9. Birthplace

Fountain Green Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Aug 29/48
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

8/2848P. Woodward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Cerebral hemorrhage

DURATION

Instant

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

_____. Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Gerald C Palmer M.D.
Active Deputy Medical Examiner
Harford County
Bellaire, Md.
Address _____ Date signed 8/27/48

M. D. or other

Date signed 8/27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

08429

186a

1. PLACE OF DEATH:

County HARFORDCity or town WHITE DE GRACE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

HARFORD MEMORIAL HOSPITAL

How long in hospital or institution?

54 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Whiteford
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

JAMESKAHOE

3.(b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

ROSE KAHOE

7. Birth date of

deceased (mo., day, yr.)

April 25 - 1867

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

8142

hrs.

min.

9. Birthplace

Harford Co., Md.
(Town, county, and state)

10. Usual occupation

FARMER

11. Industry or business

MOTHER FATHER

12. Name

LAWRENCE KAHOE

13. Birthplace

IRELAND

14. Maiden name

Unknown

15. Birthplace

Ireland

16. Informant

ARTHUR KAHOE

Address

Delta, Pa.

17.

BURIAL

Date thereof

Aug. 30 1948
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or place of burial

St. Mary's

Location

Pylesville Md

18. Funeral director

Hubert P. Watkins

Address

Delta, Pa.

19.

Aug. 2819 48

(Date read by registrar)

G. L. Lewis M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 AUGUST 1948 at 12:01 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 219 48Aug. 2719 48and that I last saw him alive on 27 AUGUST 19 48

Immediate cause of death

ARTERIO SCLEROTIC
CARDIO VASCULAR DISEASE

DURATION

Due to

Due to

Other conditions FRACTURES OF PELVIS
AND GENERAL DEBILITY.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ACCIDENT

Date of

8-27-48

Where did injury occur?

WHITEFORDHARFORDMD
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) AT HOME

Means of injury

FELL FROM SECOND

Injured at work?

STORY WINDOW

23. SIGNATURE

R. B. Norment M.D.
M. D. or other

Address

WhitefordDate signed 8-27-48

RECEIVED

AUG 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 185

08430

1. PLACE OF DEATH:

County HARFORD
 City or town HARRE DE GRACE
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

LEONARD A.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Perry Point
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

KIMMEY

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife Beatrice Kimmey7. Birth date of deceased (mo., day, yr.) Dec. 7, 19008. AGE: Years 47 Months 8 Days 22 it less than one day _____ hrs. _____ min.9. Birthplace Worcestershire, Md.
(Town, county, and state)10. Usual occupation Attendant11. Industry or business U. S. V. Hospital12. Name Elias W. Kimmey13. Birthplace Worcestershire Co., Md.14. Maiden name Laura Willey15. Birthplace Worcestershire Co., Md.16. Informant Beatrice KimmeyAddress Perry Point, Md.17. Burial Date thereof Sept 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory East New MarketLocation East New Market, Md.18. Funeral director W. A. Patterson & SonAddress Perryville, Md.19. Aug 31, 1948 G. L. Lewis M. D.
(Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 29 August 1948 at 6:35 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

29 August 1948 to 29 August 1948and that I last saw him alive on 29 August 1948Immediate cause of death Circulatory failureand pulmonary edemaDue to acute coronaryocclusion

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

Due to _____

Other conditions _____

RECEIVED

SEP 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County... Hartford CoCity or town... Benson Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... HartfordCity or town... Benson
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thomas Wilson Lochary

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced M6.(b) Name of husband or wife M Roberta Herkins7. Birth date of deceased (mo., day, yr.) June 16/1884 6.(c) If alive, give age... years8. AGE: Years 64 Months Days It less than one day... hrs. ... min.9. Birthplace Hartford
(Town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business

12. Name Thomas Lochary13. Birthplace Md14. Maiden name Cassandra Wilson15. Birthplace Md16. Informant P Paul LocharyAddress Abingdon17. Burial Date thereof Aug 16/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St IgnaceLocation Hickory, Hartford Co, Md18. Funeral director Joseph J FosterAddress Belair mar19. 8/14 48 P Lowry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 19 48 at 8:05 P.M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 44 to Aug 19 48and that I last saw him alive Aug 12 19 48Immediate cause of death Cerebral HemorrhageDue to arterio-sclerotic C.V. Disease DURATION 24 hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Regd PhysicianAddress Churchville M. D. or other Aug 13
Data signed

RECEIVED

AUG 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. In case of age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County HARFORDCity or town HAVRE-DE-GRACE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

HARFORD MEMORIAL HOSP.How long in hospital or institution? 12 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County HARFORDCity or town ABERDEEN
(If outside city or town limits, write RURAL and give nearest town)Street No. 141 POST ROAD
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WILBUR E OTSTOT

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Jana Benemidex7. Birth date of deceased (mo., day, yr.) 1 MAY 1870 6. (c) If alive, give age years8. AGE: Years 78 Months 3 Days 13 If less than one day hrs. min.9. Birthplace OHIO
(Town, county, and state)10. Usual occupation Bldg Contractor - Rtd

11. Industry or business

12. Name THOMAS GRANT OTSTOT13. Birthplace OHIO14. Maiden name FRENORA MARINESS15. Birthplace OHIO16. Informant Mr. Richard G. OtstotAddress 141 Post Rd. Aberdeen Md17. Removal Date thereof Aug. 16, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wiles, Mich.Location Wiles, Mich.18. Funeral director Henry Tarrington SonsAddress Aberdeen Md.19. Aug. 16 1948 G. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 AUG 1948 at 6¹⁰ P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 AUG 1948 to 14 AUG 1948
and that I last saw him alive on 14 AUG 1948Immediate cause of death RESPIRATORY FAILUREDue to CEREBRAL EMBOLUSDue to MURAL THROMBUS, LEFT VENTRICLEOther conditions OCCCLUSION ANTERIOR CORONARY ARTERY
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

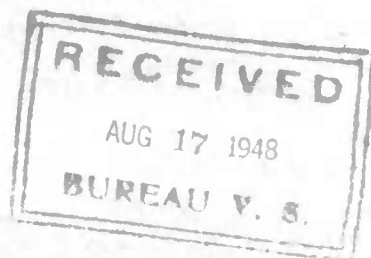
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE RB Marmont M.D.Address Havre de Grace Date signed 14 Aug 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 1860-185-

1. PLACE OF DEATH:

County HarfordCity or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 78 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 552 Green
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Carrie Boyd Pennington

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Robert Rice Pennington6. (c) If alive, give age 80 years7. Birth date of deceased (mo., day, yr.) I/29/1870

8. AGE:

Years

Months

Days

If less than one day

78627

hrs.

min.

9. Birthplace Havre de Grace
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name Francis B. Boyd13. Birthplace Maryland14. Maiden name Missouri Jackson15. Birthplace Maryland16. Informant Robert R. PenningtonAddress 552 Green17. Burial Date thereof 8/28/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Angel HillLocation Havre de Grace18. Funeral director Pennington & SonAddress Havre de Grace19. Aug. 26 19 48 G. F. Lewis m. d.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 19 48 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 14 19 48 to Aug 23 19 48and that I last saw him alive on Aug 23 19 48

Immediate cause of death

Fracture PelvisHamili Canine IschemiaArterioscleroticCerebral Hemorrhage

Due to

Due to

Other conditions Taxemia

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of June 1948Where did injury occur? Havre de Grace (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Fall Injured at work?23. SIGNATURE Charles J. Foley M.D.Address Havre de Grace Date signed Aug 26



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

486 X

08434

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Hartford Co.
 City or town Bel Air, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Hartford
 City or town Bel Air, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
 (If rural, give LOCATION)

2. (a) If veteran, name war.

3. (a) FULL NAME

Cornelia T. M. Richardson

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M6. (b) Name of husband or wife Dr Charles Richardson Sr

7. Birth date of deceased (mo., day, yr.)

Aug 20-1884

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

63

hrs.

min.

9. Birthplace

Hartford Co. Md
(Town, county, and state)

10. Usual occupation

House Wfr

11. Industry or business

MOTHER FATHER

12. Name

Wakuman B Munnikhusen

13. Birthplace

Md

14. Maiden name

Annie Farnandis

15. Birthplace

Md

16. Informant

Dr Charles Richardson Sr.

Address

Bel Air, Md

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

Aug 7/48

Cemetery or crematory

St Mary's

Location

E. M. Morton, Md

18. Funeral director

Joseph Foster
Bel Air, Md

Address

19. 8/5 48 P. Woodward
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 19. 48 at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

194619. 46to Aug. 519. 48and that I last saw him alive on Aug. 5 19. 48

Immediate cause of death

Cardiacdecompensation, acute

DURATION

Due to

Carcinoma of uterus
& local metastasis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles Richardson Jr
M. D. or other

Address

Bel Air, Md

Date signed

8/5/48

RECEIVED

AUG 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County..... Harford
 City or town..... Belair Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Kalmia
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford
 City or town..... Rural Bel Air
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Kalmia
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Mary Eliza Rolph

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) 6/23/1868

8. AGE: Years Months Days If less than one day
80 2 0 hrs. min.

9. Birthplace..... Church Hill Queen Anne Co Md
 (Town, county, and state)

10. Usual occupation..... Retired11. Industry or business..... Graduate nurse12. Name..... Wm. F. Rolph13. Birthplace..... Maryland14. Maiden name..... Charlotte Ann Beck15. Birthplace..... Maryland16. Informant..... M. Charles Max WebbAddress..... Cardiff Maryland17. Rural Date thereof..... August 25 1948

(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory..... Faunders ParkLocation..... Fredrick Road18. Funeral director..... C. W. LamoureauxAddress..... 1003 W. Baltimore St. #2319. 8/23 48 Tafowood

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 23 1948 at 6:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16 1948 to August 22 1948and that I last saw him/her alive on August 22 1948

Immediate cause of death.....
Cerebral Thrombosis (second episode) DURATION 12 hrs.

Due to.....

Due to.....

Due to.....

Due to.....

Other conditions..... Chronic cardiovascular

disease. ?

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: it death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... Willard P. Hudson M. D. certAddress..... Forest Hill, Maryland Date signed 8/23/48

RECEIVED

AUG 25 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County HarfordCity or town Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Rural - Aberdeen Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Paradise Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Jermiah P. Tobin

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Catherine Brown7. Birth date of deceased (mo., day, yr.) March 21, 1861

6. (c) If alive, give age years

8. AGE: Years 87 Months 5 Days If less than one day hrs. min. 9. Birthplace Aberdeen Harford Co., Md.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farmer12. Name James Tobin13. Birthplace Ireland14. Maiden name Martha Rigan15. Birthplace Harford Co., Md.16. Informant Mr. Edward J. TobinAddress Aberdeen, P.D. Md.17. Rural Date thereof Aug. 16, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary's CemeteryLocation House of Grace, Md.18. Funeral director Benny Tarrington & SonsAddress Aberdeen, Md.19. Aug. 14 19 48 Nellie D. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 19 48 at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 4 19 48 to Aug. 13 19 48and that I last saw him alive on Aug. 13 19 48Immediate cause of death Uremic Coma

DURATION

2 daysDue to Chronic Interstitial nephritis 10 yearsDue to arterio sclerosis 20 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lana Usebert MDAddress House of Grace Date signed Aug 13

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08436

1310

RECEIVED

AUG 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
 City or town Forest Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Harford
 City or town Forest Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Callie Jane Walters

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced
 6. (b) Name of husband or wife Robert Lee Walters
 6. (c) If alive, give age 84 years
 7. Birth date of deceased (mo., day, yr.) March 23 1967
 8. AGE: Years 81 Months 4 Days 18 If less than one day _____ hrs. _____ min.
 9. Birthplace Jefferson, Ash Co NC
 (Town, county, and state)
 10. Usual occupation house wife

11. Industry or business

12. Name Alexander Dixon
 13. Birthplace NC
 14. Maiden name Cynthia Samill
 15. Birthplace NC

16. Informant Mr John D Walters
 Address Forest Hill md
 17. md 26005 Date thereof Aug 13 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory mt zion
 Location Bel Air

18. Funeral director Martin Skurk
 Address Sanctiville md

19. 8/12 48 P. Forwood
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1948 at 1:20 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1944 to Aug 11 1948
 and that I last saw him alive on Aug 11 1948
 Immediate cause of death
Chr Cardiac Vascular Disease
with hypertension
 DURATION 1 yr
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Willard P. Hudson
 Address Forest Hill md Date signed 8/12/48
 M. D. or other _____

RECEIVED

AUG 13 1948

BUREAU V. E.